Reply to "Do not de-escalate oncology care in oropharyngeal cancer routinely"

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REPLY TO LETTER TO THE EDITOR

WILEY

Reply to "Do not de-escalate oncology care in oropharyngeal cancer routinely"

Dr. Petr Szturz and Dr. Jan B. Vermorken have made important remarks about our study "De-escalation of post-treatment surveillance in oropharyngeal cancer." They raise potential concerns about de-intensifying routine follow-up of oropharyngeal squamous cell carcinoma (OPSCC).

We suggest that follow-up of HPV-associated OPSCC could be de-intensified 2 years after treatment, since the majority of recurrences and toxicities present within 2 years.[1,2] We encourage rapid access consultation whenever new symptoms arise. Our article did not support treatment de-escalation outside randomized, controlled studies.

The prognosis of HPV+ OPSCC is excellent, with 3-year local and regional control over 90%.[3,4] Dr. Szturz and Dr. Vermoken refer to a study in which, after 3 years of follow-up, the proportion of HPV+ OPSCC patients presenting with distant metastases was only 1.5% (7 of 457).[5] The number of routine imaging studies needed to detect one late, asymptomatic distant failure of HPV + OPSCC is high. Exposing all HPV+ patients to prolonged follow-up, and repeated imaging, is not likely to produce significant survival benefits for the minority of patients with poor prognosis.

Although atypical sites of distant metastases have been reported in the literature, the most common sites are the lungs, liver, and bone, irrespective of HPV status.[1,6,7] In a study by Fakhry et al median time to disease progression was also similar in HPV+ and in HPV− OPSCC, supporting close surveillance within the first 2 years in both groups.[1]

Whether early detection of distant metastasis in asymptomatic HPV+ OPSCC patients is beneficial in terms of life quality, psychosocial well-being, or survival is yet controversial. In decelerating progression of incurable disease, the potential survival advantage and treatment toxicity should be carefully assessed in randomized, controlled studies.[8]

We agree that careful monitoring of treatment toxicity is important. Intense follow-up during the first 2 years detects the majority of side-effects, and a multidisciplinary team should be available throughout follow-up for early intervention. Traditional, clinical outpatient examinations could be partly replaced by modern methods, such as web-based screening tools, in detecting late side-effects. In the future, carefully planned treatment de-escalation protocols hopefully decrease permanent morbidity.

Intense follow-up may be justified in patients with reduced life management skills, or with lower capacity for self-assessment. Reducing routine follow-up for fit, asymptomatic patients improves availability for those who need more guidance, or quick assessment because of new symptoms. In a strict, protocol directed follow-up patients may unnecessarily wait for a scheduled appointment, even when a rapid check-up is required.

The extent to which patient preferences should guide cancer follow-up and imaging, or medical decision making in general, is an interesting issue from the perspective of health economics.[9] Dr. Szturz and Dr. Vermoken refer to a cross-sectional study by Mueller et al. In that study, the majority of head and neck cancer patients favored fewer visits than the current standard.[10]

We would like to thank Dr. Szturz and Dr. Vermoken for their valuable comments, and editors of the Head and Neck journal for the opportunity to respond to their letter.

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